Pediatric Patient Information and Consent

Child's Information			
Name	Sex ☐ M ☐ F	Birth Day	SSN
Address	City	State	ZIP
Home Phone Ok to Text ☐ Yes ☐ No	Cell Phone Ok to Text ☐ Yes ☐ No	Work Phone	
Email Address			
Preferred Language	Race ☐ Black ☐ White ☐ Asian	Ethnicity ☐ Hispanic ☐ Non-Hispanic	Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced
Child's Primary Pediatrician			

Mother's Information			
Name	Sex ☐ M ☐ F	Birth Day	SSN
Address	City	State	ZIP
Home Phone Ok to Text ☐ Yes ☐ No	Cell Phone Ok to Text ☐ Yes ☐ No	Work Phone	

Father's Information			
Name	Sex ☐ M ☐ F	Birth Day	SSN
Address	City	State	ZIP
Home Phone Ok to Text ☐ Yes ☐ No	Cell Phone Ok to Text ☐ Yes ☐ No	Work Phone	

In the Event Parent/Guardian is unable to bring the child please list two people authorized to bring child for visits		
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Authorization for Release of Information

Who do you authorize to receive information on your behalf regarding testing, results, or referrals?

Preferred Pharmacy

Do you prefer Grove Park? ☐ Yes ☐ No If not, please list who you prefer:

No Show Policy

We ask patients to call and cancel appointments 24 hours in advance if possible to allow for better use of our staff and provider's time. Patients who do not show up for a scheduled appointment and do not call to give notice will be considered a "no show." "No shows" will be billed a $25 fee.

Patient Consent for Treatment

By signing below I agree to the following:

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Grove Park Pharmacy Medical Clinic and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatment or examinations at Grove Park Pharmacy Medical Clinic.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Grove Park Pharmacy Medical Clinic Notice of Privacy Practices.
3. I authorize payment of medical benefits to Grove Park physicians or their designee for services rendered.
4. I give permission to obtain all my medical/prescription/vaccine history when using an electronic system to process transactions for my medical treatment.
5. I reviewed the Notice of Privacy Practice that is posted in the waiting area and was offered a copy.
6. I understand that I am responsible for any copay and deductible amounts as well as any charges not covered by my insurance.
7. I understand that if a child is under 16 years of age, an Adult/Guardian must be present at the time of the appointment.

Signature of Patient / Guardian / Guarantor	Print Name	Date

Pediatric Medical History

Child's Information	
Name	Birth Day

Allergies ☐ No Known Allergies

Current Medications (include over the counter medicines) ☐ No Current Medications

Family History

Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)	☐ N/A

Social History

Have you ever smoked tobacco?	☐ Never	☐ Former	☐ Current	How much? _____
Have you ever used e-cigarettes or vape?	☐ Never	☐ Former	☐ Current	How much? _____
Have you ever used smokeless tobacco?	☐ Never	☐ Former	☐ Current	How much? _____
Do you drink alcohol?	☐ None	☐ Occasionally	☐ Moderate	☐ Heavy
What is your caffeine consumption?	☐ None	☐ Occasionally	☐ Moderate	☐ Heavy
Do you use any illicit or recreational drugs?	☐ No	☐ Yes		

Surgical History ☐ No Surgeries

Past Medical History ☐ None apply

Please mark an (x) by any of these conditions you may have had in the past:

☐ Anemia or blood disorders	☐ Depression	☐ Joint Replacement	☐ Seizures
☐ Anxiety	☐ Diabetes	☐ Kidney, Bladder or Prostate	☐ Severe Headache / Migraine
☐ Arthritis	☐ Diverticulitis	☐ Liver Disease	☐ Sleep Apnea
☐ Asthma	☐ Fibromyalgia	☐ Lumbar Spine Disorder	☐ Stomach Disease
☐ Bleeding Tendency	☐ Gout	☐Lung Disease	☐ Stroke
☐ Blood Clots	☐ Heart Disease	☐ Mental Health Problems	☐ TB / Tuberculosis
☐ Bowel Disease	☐ High Cholesterol	☐ Muscle Disease	☐ Thyroid Disease
☐ COPD	☐ High Blood Pressure	☐ Nerve Impairment	☐ Other:
☐ Cancer	☐ Hyperthyroidism	☐ Osteoporosis	_____
☐ Cervical Spine Disorder	☐ Hypoglycemia	☐ Pulmonary Embolism	_____
☐ Coronary Artery Disease	☐ Hypothyroidism	☐ Reflux / GERD	